

Infectious Disease Consultants, PA

James S. Ley, MD • Wesley W. Emmons, III, MD • Maya Gupta, MD
Chad Duffalo, MD, MPH • Byungwoo Choi, MD • T. Reena Mascarenhas, MD
Elizabeth Browne Conway, PA-C

PATIENT INFORMATION:

Date of Visit: _____ Soc. Sec #: _____

Patient's Name: _____

Address: _____

City/State: _____ Zip Code: _____

Age: _____ Birthdate: _____ Sex: M / F (Please circle) __ Transgender

Marital Status: S / M / W / Partner / Legally Separated (please circle)

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Best way to contact you: Home _____ Cell _____ Work _____ (Please check one)

May we leave message at: Home _____ Cell _____ Work _____ (Please check one)

Email Address _____ (Optional – to join Patient Portal)

INSURANCE INFORMATION:

Primary Insurance Carrier Name: _____

Subscriber: Self / Spouse / Parent Subscriber Name: _____

Subscriber DOB: _____

Secondary Insurance Carrier Name: _____

Subscriber: Self / Spouse / Parent Subscriber Name: _____

Subscriber DOB: _____

Emergency Contact / Personal Representative (person(s) with authority to receive information about your health status and billing):

Relationship: _____ Phone: _____

Relationship: _____ Phone: _____

Referring Physician: _____ Phone # _____

Primary Care Physician: _____ Phone # _____

Pharmacy: _____ Pharmacy Phone# _____

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Authorization to release Medical Information:

I hereby authorize Infectious Disease Consultants, PA to release any information acquired in the course of my examination or treatment for the purposes of billing my insurance. I hereby authorize payment directly to Infectious Disease Consultants, PA of surgical and/or medical benefits. I also will be responsible for any deductibles, co-insurances or copayments that my insurance does not cover. **If 24 hours advanced notice of cancellation of any scheduled appointment is not given to Infectious Disease Consultants, PA, I agree to payment in full for the service scheduled.**

Referral Policy:

I understand that it is my responsibility as the patient to know if my insurance requires a referral or authorization(s). I understand that if I do not have the necessary insurance referral(s) at the time of my appointment(s), I will be personally responsible for the charge of the visit.

Collection Policy:

Past due accounts will be placed with a collection agency. You will be responsible for all costs of collection which may include collection fees, attorney fees, and any other fees charged by the collection agency including but not limited to a fee for a partial payment made on the past due account.

By signing and dating I am agreeing to all of the above policies.

Printed Name of Patient:

Signature of Patient:

_____ Date: _____

TO DECREASE BILLING COSTS, WE ASK THAT YOU PLEASE PAY AT THE TIME OF YOUR VISIT. THANK YOU.

Please provide the information requested in the fields below regarding diversity. This information is collected in conjunction with government and record-keeping requirements. It is completely optional for you to submit and will be used only for Equal Employment Opportunity reporting requirements.

Race: ☐ White ☐ Other Race ☐ Other Pacific Islander ☐ Asian ☐ American Indian or Alaska Native

☐ Native Hawaiian Other Pacific Islander ☐ Black or African American ☐ Hispanic ☐ Decline to Report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Report